Patient Safety Innovation Award - 2019 Nomination Form

For questions about submitting a nomination for the award, contact Casey Hutchens chutchens@IHAconnect.org.

Overview

The Indiana Patient Safety Center (IPSC) has established the annual Patient Safety Awards to recognize individuals, groups and organizations who have helped bring Indiana closer to the goal of zero patient harms. These awards will honor commitment and enthusiasm for improving patient safety in hospitals and communities across the state.

The Patient Safety Innovation Award recognizes an individual, group or program that has developed innovative ways to improve, encourage or enhance patient safety within their hospital, health system, regional patient safety coalition or professional organization. This could mean developing a new program, process or campaign or leveraging an existing process or tool in a new way. Winners will demonstrate creativity and forward thinking.

Submit your nomination by filling out the following form and submitting a brief narrative. Supporting documents may be attached to enhance your nomination.

The nomination period is open from Feb. 25 to April 8. Nominations will be carefully considered by a committee of health care professionals and patient safety advocates, with winners announced at the Patient Safety Summit June 4.

2018 Winner: The Comprehensive Transitions of Care (TOC) Pharmacy Program at Franciscan Health Hammond Hospital

The Comprehensive Transitions of Care (TOC) Pharmacy Program at Franciscan Health Hammond Hospital received the 2018 Patient Safety Innovation Award for their outstanding work improving continuity of care medication safety by targeting high-risk patients to receive a TOC pharmacist evaluation of patient's medication therapy. Through this unique approach to patient care, the team at Franciscan Health Hammond Hospital removed patient care silos by bridging the gaps in care in all aspects of a patient's healthcare experience. The Comprehensive Transitions of Care (TOC) Pharmacy Program was created to bridge gaps in transition of care from the hospital to home and, ultimately, decrease hospital readmissions of high-risk patients.

2019 Nomination Form

NOMINATOR INFORMATION

Name *

Jim Fuller

Job Title *

President

Hospital/Organization *

Indianapolis Coalition for Patient Safety, Inc.

Address *

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Email *

jfuller@indypatientsafety.org

Phone Number *

317-223-3090

NOMINEE INFORMATION

I am nominating a(n) *

- ○ Individual
- ◉ Group/Team/Coalition
- ○ Organization

If group, team, coalition, or organization, please include name

ICPS Medication Safety Workgroup

Contact Name *

Jim Fuller

Job Title *

President

Hospital/Organization *

Indianapolis Coalition for Patient Safety, Inc.

Address *

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NOMINATION REASONING

Please write a brief narrative below that describes why this nominee deserves to be recognized. Please incorporate the answers to the following questions in your narrative based on the award you indicated above.

Write response here *

The Indianapolis Coalition for Patient Safety (ICPS) Medication Safety Workgroup is a great illustration of using a regional patient safety coalition to meet the Institute for Safe Medicine Practices (ISMP) targeted medication safety best practice 14.
Over the last year, The Indianapolis Coalition for Patient Safety, Inc. (ICPS) Medication Safety Workgroup began sharing medication safety events and close calls monthly on a rotating basis at each site as well as collaborating on ad hoc issues that arise between meetings. A peer review protected forum, sharing takes the form of formal presentations, reviewing order sets, electronic health record (EHR) components, policies, protocols, discussing root cause analysis (RCA) findings, or other mechanisms, as appropriate.

PATIENT SAFETY INNOVATION AWARD

Please complete all questions below.

What patient safety initiative has this individual/group/organization created or led? *

Over the last year, The Indianapolis Coalition for Patient Safety, Inc. (ICPS) Medication Safety Workgroup began sharing medication safety events and close calls monthly on a rotating basis at each site as well as collaborating on ad hoc issues that arise between meetings. A peer review protected forum, sharing takes the form of formal presentations, reviewing order sets, electronic health record (EHR) components, policies, or protocols, discussing root cause analysis (RCA) findings, or other mechanisms, as appropriate.
In 2018, 25 unique medication safety dilemmas were addressed by the workgroup during 12 standing meetings.

What need did this initiative fill, or what problem did it solve? *

This collaboration through ICPS has achieved accelerated outcomes by sharing resources, performance targets, accountability, and lessons learned. ICPS members have undertaken projects focusing on patient-centered strategies to improve safety. Using subject matter experts from Coalition hospitals has allowed the workgroup to identify hidden risk points and errors that could easily be repeated at other sites if left unaddressed. Sharing our best practices and promoting standardization across the city should help to prevent similar errors in the future, thus decreasing patient harm.

What made this initiative innovative or unique from existing efforts? *

The Indianapolis Coalition for Patient Safety, Inc. (ICPS) provides a forum for Indianapolis-area hospitals to share best practices and work together to solve patient safety issues. A free-standing nonprofit organization (501c3), it is comprised of representatives from the 6 major health systems located in Indianapolis: Community Health Network, Eskenazi Health, Franciscan Health, Indiana University Health, Richard L. Roudebush Veterans Affairs Medical Center, and St. Vincent. Although competitors in the market place, hospital leaders came together and agreed to not compete on safety.

The interdisciplinary ICPS Medication Safety Workgroup has representation from all six local health-systems as well as a variety of clinical expertise including pharmacists, nurses, and clinical nurse specialists. While each health-system routinely takes part in safety calls and other sharing within their local organization, the ICPS interdisciplinary and inter-facility sharing is unique and provides a forum for more broadly sharing events, experiences, and learning.

What results did this initiative produce? *

In 2018, 25 unique medication safety dilemmas were addressed by the workgroup during 12 standing meetings. The following results represent significant examples of collaboration amongst sites and disciplines within the coalition hospitals. For example, Facility A (to de-identify) noted potentially serious issues with the accuracy and precision of INR results from point of care (POC) devices when compared to traditional blood draws not previously seen in INRs. Though collaboration with the POC physician manager and Facility B, it was noticed these results were not isolated to just Facility A. Data was shared with the four remaining organizations and all sites utilizing the same POC testing ceased use. This was shared with the FDA, ultimately resulting in a recall of the test strips. During the intravenous fluid shortage that began in November of 2017, led by Facility B disaster preparedness team, a city-wide ad hoc team was formed to address the critical drug shortages in partnership with a local, private emergency management organization. The team developed Consensus Standards for intravenous (IV) push medications (expanding non-traditional administration of IV antibiotics) and targeted IV to oral medication conversion. Facility C noticed a trend in adverse drug reactions with IV iron. Information was requested from the rest of the workgroup and additional sites confirmed similar incidents, highlighting the larger, more widespread issue at hand. Facility D experienced a temperature variation in a refrigerator used to store immunizations. Through this issue a subsequent system-wide barrier analysis was conducted and all gaps have been shared with the entire group. This HFEMA has prompted a renewed awareness of this issue across sites. Other examples include: smart infusion pump interoperability, CBD oil, standardizing weights as metrics only, barcode scanning workarounds, dispensing colonoscopy preparation, and others.

Has this innovative initiative been recognized by other individuals or groups, or has it been replicated by others since its implementation? *

The Indianapolis Coalition for Patient Safety Medication Safety Workgroup was recognized by the Indiana Pharmacists Alliance and presented with the 2017 Medication Safety Healthcare Organization Award.

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